and IgM as well as cytokines such as interleukin 2, interleukin 4, and interleukin 6.[16]

Ursodeoxycholic acid may be beneficial in primary biliary cirrhosis, and we now have a clearer understanding of how it may work. Unfortunately, the nature of the disease makes it difficult to show definitive long term benefit. A meta-analysis of double blind placebo controlled data is planned and may be helpful. In comparison with previously suggested agents ursodeoxycholic acid is well tolerated and non-toxic. It should be used in patients with primary biliary cirrhosis except those with end stage disease, who should be considered for liver transplantation.

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Professor Northfield has been carrying out studies on the mechanism of action of UDCA and is about to carry out a trial to determine its optimum dose in primary biliary cirrhosis funded by the pharmaceutical industry.

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Assisted suicide for depression: the slippery slope in action?

Learning from the Dutch experience

In June this year the Dutch supreme court convicted but declined to punish a psychiatrist, Dr Boudewijn Chabot, for assisting the suicide of a physically healthy patient who was stated by the court to have "a depressive disorder in the narrow sense."[1 2] This judgment has been interpreted as "a historic ruling,"[3] but outside the Netherlands it has received scant attention.[4 5]

Although the prosecutor general thought "that help in assistance with suicide to a patient where there is no physical suffering and who is not dying can never be justified," the supreme court rejected this contention. It explicitly accepted that euthanasia or assisted suicide might be justifiable for a patient with severe psychic suffering due to a depressive illness and in the absence of a physical disorder or a terminal condition.

The court did, however, find Chabot guilty because he had not obtained a second opinion examination of the patient by another psychiatrist and there was no independent expert evidence that "an emergency situation"[6] existed—the normal mitigating defence in such cases. Although the guilty verdict could have brought with it a custodial sentence, the court elected not to punish him, on the vague grounds of "the personality of the accused, as well as the circumstances in which what has been proved to have happened took place."[1]

It is difficult to reconcile some of the details in the case, such as Dr Chabot's reported claim that the patient was unlikely to respond to antidepressant drugs,[5] with standard practice in the management of what the court ruling stated was a depressive disorder, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised.[7 8] This is particularly so as antidepressant treatment had not apparently been shown to be ineffective—it had been offered to the patient but refused.

Hopelessness, along with suicidal thoughts and morbid preoccupation, are core features of depression. Nevertheless, it is the perception of the patient's subjective hopelessness that is one of the main determinants of doctors' assessments about the appropriateness and urgency of euthanasia and assisted suicide.[9]

The implication of the court's reference to the disorder being "without psychotic features" also raises concern in view of the heavy burden this places on the distinction between "psychotic" and "non-psychotic." The fact that the court mentions this distinction seems to imply that had the patient been deemed to be psychotic then Dutch mental health legislation might have been invoked to enforce compulsory treatment. An oversimplified view of the distinction between psychotic and non-psychotic depression may lead to failure to recognise that distortions of thinking and judgment falling short of delusions commonly occur in depression, with consequent underestimation of their effect. It is also important to emphasise that many apparently intractable depressions are associated with inadequate exploration of available treatment options rather than absolute refractoriness.[10]

The importance of psychiatric factors in the assessment of patients requesting euthanasia for physical suffering has also increasingly been recognised. In view of the evidence that unrecognised depressive illness can be an important factor in requests for euthanasia and that sometimes its treatment can lead to the retraction of the initial request for euthanasia, it is of particular concern that in one anonymous survey in the Netherlands a second opinion had not been sought in up to a quarter of cases of euthanasia.[9 11]

Nevertheless, the intensity of psychic pain suffered by some patients with severe affective disorder must be acknowledged. In moments of candour some professionals

may admit sympathy for the view that in severe and persistent depressive illness, when all appropriate physical treatments, including polypharmacy, electroconvulsive therapy, and psychosurgery,[12 13] have apparently been exhausted, voluntary euthanasia may sometimes seem to be as justifiable an option as it does in intractable physical illness. This, however, is not necessarily to condone it for either.

The particular problem that is raised by "psychiatric euthanasia" is the dubious boundary between psychiatric illness and understandable unhappiness. Now that this judgment apparently accepts the precedent of assisted suicide for depressed patients as being morally justifiable if not actually lawful, it is difficult to imagine how the progression to a test case regarding psychic suffering in a person who is not mentally ill can be avoided.

However psychiatrists respond to this dilemma, campaigners against euthanasia will point, perhaps with good reason, to cases such as Chabot's as evidence that the slippery slope they feared already exists. It has long been argued that if euthanasia and assisted suicide become acceptable, as they now have in some countries, for "core cases"—people who are terminally ill with physical symptoms, especially pain, which cannot be relieved by other measures but who remain psychiatrically well and fully competent—then it may be impossible to restrict the scope of these new medical interventions.[14 15] However well any legislation is hedged about with guidelines and protections against abuse, the slippery slope predicts an inevitable extension of these practices to other, more vulnerable, groups, such as those who are demented, mentally ill, chronically disabled, frail, dependent, and elderly—and perhaps even simply unhappy.

We hope that the implications of this judgment will be carefully considered in the Netherlands, Britain, and elsewhere. Finally, we are left with a quotation from George Annas, professor of health law at Boston University: "If you're worried about the slippery slope, this case is as far down as you can get."[4] We are not so sure.[16]

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Are H_2 receptor antagonists safe over the counter drugs?

Five years' experience in Denmark suggests that they are

Several factors are driving the move to make medicines that were previously obtainable only on prescription available over the counter from pharmacies.[1] One factor is the decline of paternalism and the consumerist belief that the populations of highly developed societies are educated enough to be able to treat themselves without the need to consult a doctor. Another is governments' interest in controlling expenditure on health care. A drug bought over the counter at a pharmacy not only saves the costs of any subventions given to prescribed drugs but also eliminates the cost of a consultation to obtain the prescription. Finally, the pharmaceutical industry also has an interest in increasing the sales of generic products and sees scope for doing so through advertising directed at patients who make their own decisions.[2] These forces may be irresistible. The question then becomes where to set the threshold to ensure an acceptable risk in relation to the benefits.

Danish experience may be instructive since the two H_2 receptor antagonists cimetidine and ranitidine became over the counter drugs (limited to pharmacies) more than five years ago. The decision was the result of a request from the government to the Licensing Committee for New Drugs, comparable to Britain's Committee on Safety of Medicines, to advise on major groups of medicines suitable for transfer to over the counter sales. Among others, the committee proposed the anti-ulcer drugs in view of their low toxicity, their rare and relatively harmless adverse reactions, and their extensive use. The economic gains were expected to be reduced costs for the government, because general practitioners' income would be reduced, and increased spending on medicines by consumers.[3 4]

The licensing committee added the condition that the safety consequences of this change should be monitored. Special research programmes were therefore set up to look for possible changes in the pattern, frequency, and seriousness of adverse drug reactions, in the need for admission to hospital because of complications of ulcer disease, and in the total use of the medicines.

Several problem areas were identified and examined, such as the risk of interactions with other drugs (particularly for cimetidine), the possible interaction with alcohol, and the possibility of mistreatment of other non-responsive gastrointestinal disorders. The greatest fear was of delayed diagnosis and treatment of gastric cancer. The risk of treating the early symptoms of gastric cancer exists with analgesics, antacids, and H_2 antagonists, but the failure of continued pain relief should prevent an extended delay in diagnosis and treatment. The over the counter prepara-